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ABSTRACT

This second in a series of five papers on communication reticence discusses the establishment of a setting for the treatment of communicationally reticent individuals. Eleven years of operation of a formal program at the Pennsylvania State University provides the basis for discussion of factors in the operation of the system. An eclectic philosophy of treatment focusing on speech processes rather than medical, psychological, or speech pathological problems is stressed. Treatment methods basically consist of exceedingly intense teaching of rhetorical subprocesses. Screening and selection of clients, staff training, and problems of establishing a clinical unit in the academic setting are also discussed. (KS)

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DEVELOPING A RETICENCE PROGRAM

by Kent A. Sokoloff*

In the preceding paper, Dr. Phillips outlined the theoretical issues connected with defining and diagnosing reticence. In this article I will discuss how to establish a setting for the treatment of reticence and the most effective means of helping reticent humans in that setting.

Basically, this paper is a report of what we have learned after 11 years of operation of a formal program designed to help problem communicators at The Pennsylvania State University. The following issues will be dealt with: philosophy of treatment, treatment method, screening and selecting clients, staff training, and problems associated with establishing a clinical unit in an academic setting.

Philosophy of Treatment

Our philosophy of treatment is eclectic. We will try anything within legal and moral boundaries to help our clients. No treatment possibility is ruled out. Any method that seems warranted to the needs of the client can be tried so long as it is based on the communication process, and so long as there is reason to believe it will do no harm.

A competent reticence instructor is not permitted to make judgments on a medical, psychological or speech pathological bases unless he is legally certified to do so. Treatment must focus on speech processes. This last point is quite important. Since the diagnosis of reticence is a negotiation between the prospective client and an expert, we avoid locating problems for which we can offer neither treatment nor referral.

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In the area of reticence, the act of discovery is, in part, the act of creating disorder. Therefore, the diagnostician always runs the risk of creating more problems than are practically solvable; the result is that the client might leave in worse condition than when he came for treatment.

Thus, the final concern of treatment is that under no circumstances is it ethical for a person to leave treatment in worse condition than when he arrived if that decrease in capabilities is traceable to therapy offered. A therapeutic approach which benefits many at the cost of a few is not an appropriate therapy. This is not to say that the approach one takes will benefit all (that is unlikely). It is to say that any therapeutic approach should help as many as possible and injure none. This implies individually designed treatment.

A Treatment Method For The Reticent

Before describing our approach toward treatment, let me take the unorthodox step to argue first that the treatment works. A recent 5 year long longtitudinal study by Oerkvitz showed an 85% effectiveness rate through the use of this treatment method.[1] A horizontal case study investigation by Metzger also demonstrated the success of this treatment program.[2] Finally, this approach to helping reticent humans is the result of 11 years working with problem communicators. During this time the Penn State program has tried other treatment approaches (which are currently popular) like systematic desensitization[3] and sensitivity training[4] which proved neither effective nor safe.

Our approach to treatment can generally be described as an exceedingly intense and careful job of teaching rhetorical subprocesses. If

a person comes to us with a problem in speech, we must get him to understand the sub-processes of communication and how to transform that theoretical knowledge into appropriate personal behaviors designed to achieve a persuasive end. Furthermore, he must have sufficient control over his acts so that he can critique and modify his own communicative behaviors. The substantive content areas of concern are:

1. Learning to specify goals which speech can attain.
2. Learning to analyze audiences to which speech is to be directed in order to select content of what shall be said.
3. Learning to find ideas and arrange them for speech.
4. Learning to deliver ideas to particular audiences.
5. Learning to monitor the responses of audiences in order to assess and establish a base for continued improvement.

This learning takes place within the relatively common pedagogical process of goal setting.[5] Goal setting in reticence instruction is the process of specifying as concretely as possible what a successful communicative interaction would be in a specific situation. Once the student understands what a successful speech act would be for him and why, the remainder of instruction is devoted to giving the student knowledge and skills that enable him to complete the goal. A segment from a client's goal analysis might clarify this discussion.

Goal: To be an effective communicator in a group setting.

Situation: A "cocktail buffet" given in honor of a new professor and his wife in order to introduce them to other members of the academic community and their wives.

I would consider the goal to be achieved if:

1. I spend at least one hour at the party.
2. In addition to the new faculty and his wife, I introduce myself to at least 3 new people and:

A. They introduce themselves to me.

and, B. I talk to each of them for at least 3, but no longer than 10 minutes.

and, C. I find that I have at least one common interest (other than anything academically related) with at least one of these people.

and, D. If this person is standing, I keep a distance of at least 2, but no more than 3 feet, and we establish eye contact at least 3 times/minute.

or, E. If this person is seated, I am seated, preferably, either directly or diagonally across from them, and we establish eye contact at least 4 times/minute.

and, F. One of these people is a male.

3. I know when to excuse myself, and move on, e.g.,

A. I'm talking to a person I have just met and someone comes over whom they know, but I don't, and:

1. one minute has passed, and they haven't introduced me to this new stranger.

or, 2. They introduce me, but then the two of them:
-- turn toward each other, avoiding eye contact with me
and, -- make no attempt to include me in the conversation, i.e.,

a. They talk about something that is known only by a select few; namely, themselves.

or, b. They talk about personal issues.

or, c. They talk about something that I can relate to but they either ask me no questions about my views, or else they offer no response (either word or gestures) to any comment I make.

or, B. I start talking to a person I've just met, and:

1. They answer my first three questions with 1 word answers, and make no attempt to pick up from there.

or, 2. They create interruptions, i.e.,
-- they keep looking around the room and waving to any and every person that looks their way
or, -- they begin to stop people as they walk past us in order to make some kind of comment.

or, 3. They start talking about something completely

inappropriate, e.g., their present method of birth control.

or, 4. They stand less than 2 ft. away from me and they start making physical contact, i.e., grabbing my hand or patting my back, more often than two times in the first two minutes of conversation.

4. I talk to my husband, exclusively, no longer than 10 minutes in total.

5. I talk to other people that I already knew fairly well before the party no longer than 20 minutes in total.

The points to recognize about this particular example are:

1. The goal analysis (which directs all instruction) focuses on the communication process not on what the student feels about the speech act.

2. There is an emphasis on substance, judgment and analysis of interaction rather than on the personal appearance or movements of the student. In this way, the client learns that if he has little of value to present or cannot present a viewpoint coherently, it will not matter what the client looks like. For many students the allegedly disruptive physical behaviors (i.e., vocal pauses, shaking) disappear with experience in and understanding of communication. Others realize that some of these behaviors and feelings in communicative situations are the norm or simply do not interfere with the interaction.

3. The goal is realistic. It describes a situation which gives the individual difficulty.

4. The goal can be completed successfully by that individual given the communicative competencies with which the student enters and the amount of help the reticence instructor can provide in a prescribed amount of time. It is preferable to complete a series of smaller goals that move toward a complex goal than to set a single massive goal. Moving in small steps permits periodic assessment of progress for alteration of instruction and prevents any client from suffering a catastrophic defeat.

Students are trained to phrase their goals to this level of specificity. Treatment through continual procedure of goal setting and instruction continues until the client no longer desires help or until the client reaches a state of competency where regular speech instruction is preferable to clinical work.

The final issue to be discussed is how reticence treatment differs from standard instruction. First, the therapist cannot use a syllabus which is extrinsic to the therapist-client relationship. The instructor must negotiate with the student a particular "syllabus" for his treatment. An instructor can no more dictate the nature of treatment than he can dictate the diagnosis of the problem, nor can he make any assumptions about the skill and knowledge level of his client. If the instructor could make a priori generalizations about such matters, then it would be unlikely that the client was disordered. That is, the nature of the problem as an individual negotiation rather than a disease with a common etiology, precludes generalized skill levels. The therapist must start with each client on the level at which the client is functioning.

Although the substantive content is similar to any speech course, there are concerns the reticence instructor has that are not the province of a regular speech instructor. Diagnosis of a disorder is a problem unique to the reticence instructor. It is quite difficult to sort out communication problems from other problems a client might have. (There is almost always a problem trying to convince a client that success in speech has nothing to do with magic or the "vibes.") Many reticents do not recognize that success at oral communication is a matter of learning skills rather than a "natural" or "spontaneously" developed behavior.

Locating and Screening Reticence

Now is the time to state categorically that locating, screening, or treating reticence should be a voluntary procedure. It is voluntary because the diagnosis of a speech disorder requires a willing participant. Without voluntary commitment the therapist risks manufacturing a

non-negotiated difficulty (i.e., creating a problem which potentially was not there originally). These are voluntary procedures because no treatment will benefit a client without his participation. Finally, these procedures are voluntary because there is no moral justification for forced diagnosis and treatment of a speech disorder and great moral justification for helping those with a problem who ask for aid.

Once voluntary procedures have been established, there is little difficulty finding reticent people. The aspects of our clinical operations designed for the community are advertised through "announcement" sections of various media. The major portion of our clinical offering works in conjunction with our basic speech performance course at the University. The first day of class all students are given a sheet which asks if the following statements are descriptive of them:

1. You may have difficulty asking questions in class and participating in class discussions. You may be reluctant to strike up acquaintances with classmates.

2. You may shy away from speaking to professors after class and avoid office conferences.

3. You may feel apprehensive at employment interviews and uncertain about how to communicate on the job with your boss and fellow employees.

4. You may be uneasy about committee work and feel that you don't contribute your fair share in group problem solving discussions.

5. You may have difficulty meeting strangers and opening up new friendships. In social situations, you may find yourself a non-participant on the fringe of the group.

6. You may be unusually troubled, feel physically ill, shake, or sweat when you have to present formal reports in public situations.

If they identify themselves in these statements and want help, the students are asked to come to our offices for interviews with qualified staff members. In this interview we try to distinguish among those who

could benefit most from special instruction (reticence treatment), those who have concerns but can benefit from regular instruction, and those fakers who are looking for what they mistakenly believe is an easy way out of a required course. We screen approximately one-third of those we interview into reticence sections. Operating this way, we treat over 200 people a year. Once accepted into the special program, students are re-interviewed and observed for refinement of problem areas. All screening is done through interview and observation. We do not use paper and pencil measurement techniques because none exist which will deal with the problem of reticence and because it is theoretically ambiguous how such measurement devices could be of any use in screening or refined diagnosis.

Selecting and Screening Staff

Although the Oerkvitz study showed an 85% success rate independent of instructor, that is not to say that goal setting will work without a competent staff. It does suggest that if a program has a competent staff, proper diagnosis and placement, and a proper institutional environment, then the idiosyncratic style of the instructor will not significantly affect the success of the goal setting procedure.

Only one-third of the people who desire to work in our program are judged competent to be given clinical responsibility. Of that one-third only one-half are given consistent clinical responsibility. The reasons why people are not permitted to work in the clinical program are an important insight into selection of personnel. We reject potential staff members because:

1. By working with the reticent they believe they can both hide and overcome their own difficulties. This is not an uncommon problem to the "helping professions." This type of individual when placed in a position of authority will often brutalize their clients and/or exhibit

characteristic #2, below.

2. They become too emotionally involved with their clients. It is easy to become so concerned and identified with the personal tragedies in a client's life that the clinician becomes overly protective of the client's psyche. At this point the clinician usually loses the ability to give the necessarily honest assessment and critique of a client's speech.

3. They cannot take the pressure of intensive personal contact of at least one hour per week per client. It takes this minimum time to make clinical progress.

4. They lack basic intellectual and teaching competencies.

5. They are unable to learn the special skills needed for reticence instruction.

6. After a more detailed understanding of the program, they realize that reticence work is something they are not profoundly interested in doing.

What we are looking for in staff are:

1. Highly competent rhetorically, rather than cybernetically, based speech teachers. The greater the knowledge, skills and adaptability of the individual, the better. The more skill improvement options one can present to a client, the better.

2. People who see clinical work as a challenge to their skills and who believe that clinical work is worth doing. This attitude saves the client from dealing with those who would be harmful or useless to him.

3. People who can learn and use the special skills necessary to competent clinical performance.

Presuming the prospective staff member has met all the general requirements, there are two necessary areas of training. The individual should intern (under constant supervision) in as many of the components of the reticence program as possible. This will permit a judgment of the prospective staff's ability to work in the clinical setting. Second, potential staff should have working knowledge and clinical experience in speech pathological and psychoneurotic disorders. This knowledge and experience is quite useful in diagnosis and treatment of reticence.

It helps the staff member sort out types of difficulties the individual has, recognize potential referrals which will be beneficial to the client, and permits planning of treatment so that it does not exacerbate other problems a client might have.

Establishing a Reticence Program in the Institutional Setting

Although economics seems to dictate most institutional decisions, I offer this encouragement: if there is on-going speech training (not speech pathology) operating at your institution then you can legitimately integrate a reticence option into any basic speech performance offering. This would create credit hour generation (or a like equivalent) without altering the teaching load or financial status of the speech department.

However, I suspect that many will have to work with reticent people as a labor of love until he can provide intra-institutional evidence (i.e., documentation of numbers and changes in people worked with) to administrators.

In any event, let me make three suggestions about establishing a program:

1. If you do not feel competent, if you cannot find competent staff, or cannot find sufficient competent staff that has the time to see clients to completion of treatment (i.e., when the individual no longer has a problem), then do not start the program. One has a clinical responsibility not to leave clients stranded.

2. If you establish a program remember your primary obligations to the client. They are humans with problems, not sideshow freaks or subjects for the research hack. Some of the clients are exceedingly fragile. They will be destroyed by some of the traditional 'college sophomore" manipulations. Avoid using the class as a research lab.

3. If you establish a program, try to make contact with other clinical service units (i.e., speech pathology and psychiatry). It is helpful to have trusted specialists for both referral and advice.

FOOTNOTES

1. S. K. Oerkvitz, "Reports on Continuing Effects of Instruction in a Specially Designed Speech Course for Reticent Students," (unpublished M.A. thesis, Pennsylvania State University, 1975).

2. N. J. Metzger, "The Effects of a Rhetorical Method of Instruction with a Selected Population of Reticent Students," (unpublished Ph.D. dissertation, Pennsylvania State University, 1974).

3. D. Kleinsasser, "The Reduction of Performance Anxiety as a Function of Desensitization," (unpublished Ph.D. dissertation, Pennsylvania State University, 1968).

4. G. Phillips and D. Butt, "Reticence Revisited," Pennsylvania Speech Annual, XXIII (September, 1966), 1-18.

5. Our introductory text is R. Mager, Goal Analysis (Belmont, Calif.: Fearon Press, 1972).